Frequently Asked Questions
CVS Caremark Prescription Drug Program Changes November 1, 2011

OVERVIEW

Effective November 1, 2011, the State of New Hampshire's Prescription Drug Benefit Program for all active employees will include clinical program changes which may affect how you receive your medications. These programs apply to both retail and mail order processes and primarily focus on promoting the use of generic medications, higher quality care and patient safety, including medication adherence. Communication between you, your doctor and CVS Caremark pharmacists will ensure that you receive appropriate medications to safely and effectively treat your condition(s).

The intent of these programs is to provide the most cost effective and clinically appropriate medication for all members. They are not intended to interfere with your doctor's care or treatment.

In general, the Generic Step Therapy and Quantity Limits Programs implemented have raised the most questions and concerns from members. These *Frequently Asked Questions* are being provided to share specific questions related to both programs to help you effectively use your prescription drug benefits.

IF YOU HAVE QUESTIONS

All contact information is located at the end of this document, including the CVS Caremark Prior Authorization (PA) toll-free numbers for physicians to access only.

PROGRAM AND PROCESS CHANGES

Q. How have the employees been educated about their responsibility in this new process? Please provide specifics on outreach methods to both members and physicians.

A. LGC mailed a brochure communication to all employees in early October 2011 announcing the changes to the State of New Hampshire's Prescription Drug Benefit Program. The brochure outlined what you should know and do about the program changes and processes. CVS Caremark mailed a benefit booklet and summary plan description in late October 2011 to all employees.

In October 2011, CVS Caremark also sent personalized letters to all members affected by the program changes with any refills due on or after November 1, 2011. Members were encouraged to reach out to their doctor to discuss the best form of treatment and to obtain a Prior Authorization (PA) if required.

CVS Caremark also sent various communications directly to physicians by letter and/or fax for their patients. All communications sent provided helpful information to physicians about coverage and PA process requirements beginning November 1, 2011.

Q. Are the pharmacies able to work with the doctors on these issues or is it the responsibility of the member to work directly with their doctor to comply with the conditions of these programs?
A. Processes are in effect to assist members and physicians through these program changes. However, it is in the member's best interest to be familiar with the programs and to discuss the conditions with their medical providers in advance to avoid any disruption in coverage. Upon receiving the personalized letters, the member may, and are encouraged to, contact their physician in advance to discuss treatment options and to initiate the prior approval process if necessary.

Q. Are the individuals answering the two help telephone numbers provided in the initial communications trained and able to answer all the questions associated with these program changes?
A. Yes; please note that CVS Caremark Customer Care Representatives are available 24 hours a day seven days a week and LGC Enrollee Services Representatives are available Monday through Friday, 8:30 a.m. to 4:30 p.m.

Q. How often will the list of medications affected under the Quantity Limits and Generic Step Therapy Programs be reviewed for additions/deletions? Where will the revised lists be published for employees to review?
A. The list of medications and therapeutic categories affected under the Quantity Limits Program are reviewed on an annual basis by CVS Caremark. The review is based on new drug approvals and/or FDA indications.

Medications and therapeutic categories affected under the Generic Step Therapy Program are reviewed on a quarterly basis and consist of market changes with regard to new generics and brand name medications becoming available.

The list of medications and updates will be published on the State's Employee Benefits website at ***www.nh.gov***.

Q. Can we still opt out of the mandatory mail order requirement for maintenance medications? There is nothing in the initial brochure communication that speaks to this provision?
A. Yes; that program and process have not changed. To opt out of the maintenance mail order program, you may call CVS Caremark's Customer Care toll-free number. However, you may want to consider mail order when appropriate to reduce your out-of-pocket expense.

Q. Will the State of New Hampshire reserve the right of final appeal?
A. If a PA is denied, the member and physician always will have the right of appeal. This process is established under the provisions of the Patient Protection and Affordable Care Act and covers both internal and external assessment. The State of New Hampshire is not qualified to make any clinical assessments which would override this process.

PRIOR AUTHORIZATION (PA) PROCESS

Q. How much lead time will employees be given for their doctors to submit a PA?
A. The time your doctor will have to complete and submit the PA to CVS Caremark may depend on the scheduled date of your next refill. Physicians are encouraged to complete this process as quickly as possible to avoid any disruption in treatment or coverage. If a PA is not received and a refill is scheduled, the refill may be affected if physicians do not respond to the PA request promptly.

Q. How do these programs affect new or existing prescriptions? Is prior approval required for existing prescriptions? Does the change go into effect once prescriptions expire?
A. The programs are effective for any new or existing prescriptions filled on or after November 1, 2011. If a prior approval is required, you should have your doctor call CVS Caremark to initiate the PA process for you as quickly as possible. While CVS Caremark or your local retail pharmacist may reach out to your doctor directly by phone and/or fax to initiate the PA process, you should also contact your doctor to expedite the PA process for your prescription(s) if required. You can also ask CVS Caremark to fax a PA form directly to your doctor. Once the PA documentation is returned to CVS Caremark, the PA will be submitted for review and a determination is generally made within 24 to 72 hours.

Q. How are the medical providers involved in this PA process?
A. First, and most important, the medical provider and the member should discuss what treatment is best for the specific condition. Medical providers are always provided the opportunity to request a PA for continued coverage under the plan. They may also call the pharmacists at CVS Caremark if they have any questions. Physicians are encouraged to complete the PA criteria request form if necessary **prior to** your next renewal or refill request for new or existing prescriptions. Alternately, you can choose to receive the medication not covered under the plan and pay 100% of the cost.

Q. How will the retail and mail service pharmacies work with physicians if a member is affected by the program changes and new PA requirements?
A. The local retail pharmacist receives an alert message at the time he/she is filling any prescription with limits or if the generic alternative is required. The retail pharmacist may call the doctor on your behalf to discuss your treatment needs and to recommend contacting CVS Caremark for a PA if necessary.

If the prescription is filled through mail order a CVS Caremark representative will reach out to your doctor directly prior to filling the prescription to discuss your treatment needs and to initiate the PA process if necessary.

Physicians are responsible for providing the necessary information and documentation in order to initiate the PA process with CVS Caremark.

Q. What medical documentation is required from the doctor to substantiate medical necessity?
A. The initial PA process is a series of "yes/no" questions which must be answered by the physician. It is not intended to be overly complex or time consuming for physicians. Based on the physician's responses, additional medical documentation may be required. In most cases, simply completing the PA criteria questionnaire form will satisfy the program requirements.

Q. How long is the prior approval or authorization in effect for?
A. PA's vary by therapeutic class and most are effective for up to six months to two years. CVS Caremark will automatically reach out to your doctor to initiate the authorization process upon expiration. It is recommended that you be aware of the expiration date included in your original approval letter. It is helpful upon expiration to reach out to your doctor directly to expedite the response to CVS Caremark's PA renewal request.

Q. Can my doctor's request for prior authorization be denied? Under what conditions or circumstances?
A. The PA questionnaire includes a series of "yes/no" questions for physicians to answer based on their patient's medical condition(s) and treatment needs. An example of a PA denial would be if the physician does not document an allergy, medical condition(s), or a potential adverse drug interaction/effect due to a change in treatment.

Q. What recourse do I have if my doctor's PA is denied? Can we appeal?
A. You or your doctor will always have the right to appeal any coverage determination made by CVS Caremark. This process is established under the provisions of the Patient Protection and Affordable Care Act and covers both internal and external assessment. You can request an appeal by calling CVS Caremark at 1-888-726-1630 or by mailing your request to:

CVS Caremark
Appeals Department
MC109
PO Box 52084
Phoenix, AZ, 85072-2084

Appeals may also be submitted with the appropriate documentation by you or your doctor via fax. The fax number is 1-866-689-3092.

QUANTITY LIMITS PROGRAM

Q. I received a letter about the quantity limitations of the program, but my prescription is within the limits. Why would I receive this letter?
A. We wanted you to be aware of the limits in the event your doctor makes any changes to your prescription in the future.

Q. If my doctor prescribes a thirty or ninety day supply of a medication that is on the quantity limits list, what is my copay if the prior authorization (PA) is approved? Generic? Brand?
A. If the prior approval for the additional supply of medication as originally prescribed by the physician **is obtained in advance** of filling the next prescription or refill on or after November 1, 2011, the applicable generic or brand name copay will apply.

If the approval is **not** obtained in advance of filling the next prescription or refill on or after November 1, 2011 and the prescription exceeds the plan limit, you can choose to pay the applicable copay at that time for the medication dispensed in accordance with the plan limit, or pay 100% of the cost for the additional supply of medication. If you choose not to pay 100% of the cost and later request to receive the additional medication **after the prior authorization is approved**, you will be responsible for paying an additional copay upon receipt of the additional medication.

Please note that once the approval is in the CVS Caremark system, future prescriptions and refills will be filled for the quantity as prescribed for one copay.

Q. Is pain management medication for chronic pain included in the limitations?
A. No; as of November 1, 2011 there is one medication in the pain management category subject to the plan quantity limit (Stadol Nasal Spray).

Q. What provisions have been made if I am currently on medication daily that is being changed to a limited amount to ensure transition time is medically safe per my doctor's treatment?
A. Clinical PA reviews are generally completed within 24-72 hours of CVS Caremark's receipt of the PA. If a limit is required, the prescription can still be filled during the PA process at the reduced quantity; your applicable generic or brand name copay will apply. Alternatively, if you would like to pay the full amount beyond the limited quantity, you can obtain the additional supply by paying 100% of the cost. If the PA is approved for a greater quantity, you can request the additional supply at that point; however, please note that under this condition you would be required to pay another copay for the additional supply dispensed.

Q. What drugs are included under the Quantity Limits Program and what are the limitations?
A. There are several therapeutic categories or classes where quantity limits apply. Please note that these medications can change at any point based on the clinical and/or FDA indications for limitations, product approvals or withdrawals, and other market changes.

Generally, the list of affected medications and therapeutic categories are reviewed by CVS Caremark on an annual basis.

The list of medications and updates will be published on the State's Employee Benefits website at ***www.nh.gov***.

Q. Who determines what quantity limits are appropriate for treatment? If the doctor writes a prescription, why would this not be sufficient as authorization?
A. The PA clinical criteria utilized is established by physician and pharmacist experts in accordance with FDA-approved indications, guidelines and recommendations. The program changes implemented require the appropriate processes to be followed by all physicians. Physicians are responsible for completing the appropriate documentation to ensure no interruption in coverage or treatment for their patients.

Q. I have daily migraines? Are medications that are used to prevent migraines from recurring limited under this program?
A. Both acute and/or prevention medications are included in the anti-migraine therapeutic category of the Quantity Limits Program. The clinical criteria used for the PA process is established by physician and pharmacist experts in accordance with using FDA-approved indications, guidelines and recommendations.

GENERIC STEP THERAPY PROGRAM

Q. Must I wait for my next refill for the pharmacist to contact my doctor for the generic alternative or prior authorization?
A. No; you can contact your doctor directly to discuss generic alternatives for your medication or to initiate the PA process before your next refill is due. That way there will be no possible interruption in your treatment.

Q. Do I need a new prescription from my doctor to change to the generic alternative?
A. Yes; your doctor must authorize a change to the generic alternative by providing you, the retail pharmacist, or CVS Caremark's Mail Service Pharmacy with a new prescription.

Q. What copay will I pay under the Generic Step Therapy Program?
A. If your doctor authorizes a generic alternative, you will pay the generic copay. If your doctor completes a PA request form and it is approved, the brand name medication will be

covered and you will pay the applicable brand name copay. If the brand is not approved, your medication will not be covered under the plan; you may only receive the brand medication if you pay 100% of the cost in this case.

Q. How long is the history period for previous tried generics for the Generic Step Therapy Program?
A. The history period varies by therapeutic category or class; however, it is generally 180 or 365 days.

Q. I have been on cholesterol medication and tried generics several times to no avail and I am finally stable on Lipitor. Will I have to again try a generic if it has been more than one year? What specific documentation would be required to continue on Lipitor?
A. Lipitor is not a medication affected under the Generic Step Therapy Program due to a newly released generic equivalent. Pharmacies will automatically begin substituting new or existing prescriptions with the generic unless the prescription on file included "dispense as written" or similar instructions. Lipitor is currently considered a preferred brand name; however, this is subject to change in the future now that a generic equivalent is available. CVS Caremark will notify members directly if the medication, Lipitor, changes to non-preferred status resulting to a copay increase.

Lipitor will be subject to another program currently in effect where you will pay the difference in cost between the generic equivalent and brand name, plus your generic copay, if you personally prefer the brand name Lipitor. If your doctor includes "dispense as written" or similar instructions on the prescription, you will pay your brand name copay only.

For the other cholesterol lowering medications affected under the program, if you have tried generics in the past you may have fulfilled the generics first requirement, depending on when you tried the generics. If you were unable to take generic alternatives for medical reasons, your doctor may initiate and complete a PA request for the brand name medication.

Q. What if I have an allergy to the ingredients or do not respond well to generic medications? How will I be affected?
A. If the generic alternative was not effective because of a medical condition, allergy, or you have tried the generic alternative with unsuccessful results, you should contact your doctor to discuss what other alternatives may be considered. Your doctor may determine that the brand name is only effective for treatment and he/she should contact CVS Caremark to begin the prior approval process for the brand name medication on your behalf. The allergy and/or medical condition would be one of the questions specifically included on the PA questionnaire used for the determination. Upon approval, the brand name medication will be covered under the plan for your applicable brand name copay.

The prior approval process is generally completed within 24-72 hours upon receiving the necessary information included in the PA from the physician.

Q. How many generics do I have to try before I can receive the brand name?
A. The plan requires the use of one generic alternative in the therapeutic category or class first before the brand name medication will be covered under the plan.

Q. How long do I need to stay on the generic alternative before returning to the brand name medication? What if I'm having an adverse effect to the generic alternative?
A. Generally, the plan requires that you try the generic alternative for a 30 day period. The purpose of the 30 days is to ensure that you have tried the generic for an adequate period of time prior to indicating or determining that the generic may not be effective. Once the 30 day period is satisfied, the plan will provide coverage for the brand name medication if your doctor authorizes a prescription change for you to return to the brand name for treatment.

You should contact your doctor immediately if you are having an adverse effect due to an allergy or other medical condition to discuss your treatment options. If your doctor determines that you must return to the brand name medication immediately during the 30 day period, your doctor must initiate an escalated PA request with CVS Caremark immediately for the brand name to be covered under the plan.

Q. How does a generic alternative differ from a generic equivalent?
A. A generic alternative is a generic within the same therapeutic class which is not chemically identical to the brand name. A generic equivalent is chemically identical to its brand name counterpart.

Q. Do all therapeutic classes or categories have a generic alternative or equivalent? Why would we substitute a generic alternative in lieu of generic equivalent under the Generic Step Therapy Program?
A. No; not all therapeutic classes or categories have generic alternatives or equivalents available.

The brand name medications and generic alternatives targeted under the Generic Step Therapy Program are considered largely interchangeable for the therapeutic classes selected under the program since they have the same mechanism of action and similar side effect profiles. The brand name medications selected under the program do not have a generic equivalent available; only FDA-approved generic alternatives.

Q. Will the pharmacy contact my doctor to discuss the best generic to replace the brand name medication?
A. At the retail pharmacy, if the generic alternative does not appear in your history, the pharmacist will receive an alert message with generic-criteria first and a toll-free number for your doctor to call CVS Caremark to initiate the PA process for the brand name if necessary. The retail pharmacist may then contact the doctor directly on your behalf to discuss the generic

alternative(s) and to obtain authorization to fill the prescription with a generic. Please note that retail pharmacists are not required to reach out to your doctor for you.

CVS Caremark Mail Service Pharmacy will contact your doctor directly to discuss the generic alternative(s) and to obtain authorization to fill the prescription with a generic, or to initiate the PA process for the brand name if necessary.

It is recommended that you monitor the process to avoid any interruption in coverage or treatment.

Q. What medications are affected under the Generic Step Therapy program?
A. There are several therapeutic categories or classes for which the plan requires using a generic alternative first. Please note that these medications can change at any point, based on

the clinical and/or FDA recommendations, product approvals or withdrawals, and other market changes. Generally, the list of affected medications and therapeutic categories are reviewed by CVS Caremark on a quarterly basis. The most updated list of medications and therapeutic classes affected under the program are included in the CVS Caremark benefits booklet sent to you in late October 2011.

The list of medications and updates will be published on the State's Employee Benefits website at ***www.nh.gov***.

Q. Under the Generic Step Therapy Program, will a generic alternative be required unless the physician completes a prior authorization?
A. Yes; brand name medications will only be covered by the plan if you have tried one of the generic alternatives first for the therapeutic classes being targeted within the history review period, or your doctor can obtain approval through the PA process.

If your prescription history shows use of a generic alternative within the history review period, a brand name medication may be provided and covered under the plan. If not, or if you have tried an alternative beyond the history review period, your doctor must complete and receive approval through the PA process in order for a brand name medication to be covered by the plan.

For all your pharmacy-related questions, including the status of prescription orders or refills, you should call:

CVS Caremark
Toll-free number: 888.726.1630

Representatives available 24 hours a day, seven days a week
(Except Thanksgiving and Christmas)

Prior Authorization Toll-Free Numbers for Physicians Only:
Generic Step Therapy Program: 877-203-0003
Quantity Limits Program: 800-626-3046

If you have questions about enrollment, eligibility, or any other prescription drug benefit inquiry you should call:

LGC
Toll-free number: 800.527.5001

Representatives available 8:30 a.m. – 4:30 p.m. (EST) weekdays